FAQ

Q: How do providers and hospitals register for the program?

A: Providers and hospitals can begin the registration and attestation process now. This consists of two steps:

Step one: register with CMS's Registration and Attestation site at https://ehrincentives.cms.gov/hitech/login.action .

Step two: register with Iowa's state level registry- Provider Incentive Payment Portal (PIPP) at www.imeincentives.com . Provider and hospitals can begin the enrollment process with CMS, but will not receive payment until they complete the attestation process with PIPP.

Q: How will I be notified that my information was received in PIPP?

A: After you register at the CMS site you can initiate the PIPP application the next day.

Q: How long until I will receive payment?

A: Payments are made weekly as part of IME's normal payment cycle. If all of the information that you have submitted is correct the estimated wait time is about three weeks.

Q: How do I see the amount of my payment and for which provider?

A: The remit of the payee NPI in which you applied with.

Q: What types of hospitals are eligible for incentive payments?

A: All children's hospitals, acute care hospitals and critical access hospitals are eligible for incentive payments. Acute care hospitals must have a Claim Control Number that has the last four digits in the series 0001-0879 or 1300-1399 and an average length of stay of 25 days or less. An acute care hospital must also have 10% or more of its discharges attributable to Medicaid patients in the preceding hospital fiscal year.

Q: Where do we find our CCN? Is it the last 4 digits of our Medicare Provider number?

A: Incentive payments for eligible hospitals will be calculated based on the provider number used for cost reporting purposes, which is the CMS Certification Number (CCN) of the main provider (also referred to as OSCAR number). For the Medicaid incentive program hospitals must have a CMS Certification Number ending in 0001-0879 or 1300-1399.

Q: What is meaningful use?

A: Meaningful use of an EHR is demonstrated by providers and hospitals reporting on a number of required functional and clinical objectives established by CMS. For 2011, the Medicaid EHR Incentive Program will not be accepting reports on the meaningful use objectives and providers and hospitals will receive the first year payments by demonstrating AIU. Beginning in 2012 the program will accept reports on meaningful use objectives, and providers will be required to submit these reports in order to continue receiving payments after their AIU year.

Q: What does Adopt, Implement or Upgrade (AIU) mean?

A: In the first participation year of the EHR Incentive Program, eligible providers and hospitals will receive the incentive payments by adopting, implementing or upgrading (AIU) a Certified EHR. CMS defines AIU as:

- **Adopt**--to acquire and install a certified EHR system
- **Implement**-- to begin using a certified EHR system
- **Upgrade**--to expand a certified EHR system that is already in use

Q: As an Eligible Hospital, what if during the meaningful use period our Medicaid volume increases? The modeling spreadsheet is based on Medicaid allowed discharges for the last three fiscal years, is this amount of incentive refigured every year?

A: We will recalculate the incentive payment for subsequent years if the data changes. Note this might also cause a decrease in the overall payment amount.

Q: What is a payment year for hospitals?

A: Hospital payment years are based on the federal fiscal year, running from October 1 – September 30. We are currently in FFY 2012, which would be considered your first payment year. The second payment year would be FFY 2013, beginning in October 1, 2012.

Q: What is the definition of a pediatrician?

A: A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this sub rule, a "pediatrician" is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

Q: Please define ED "encounter". In other words, is it an ED visit (defined by CPT code)? Is it simply a patient count? Is it the number of times a patient walks into the ED (i.e. If I show up twice in one day, is it one encounter or two)? If I get admitted through the ED and bill the ED separately as outpatient, is this counted as one ED encounter in addition to a patient day?

A: An ED encounter is a visit on any one day. If a patient shows up twice in one day, that is considered one encounter. If the patient shows up twice on different days, those are two encounters. How the encounter is billed is irrelevant. Inpatient days are counted by discharges.

Q: If a Nurse Practitioner (NP) works in a Family Practice office where the physician patient volume threshold meets 30%, but the NP Medicaid patient volume is only 28% and bills under the physician, does the NP qualify for an incentive even though she does not meet the 30% patient volume?

A: No, not on their own individually, but they can if they use a clinic level approach to calculate patient volume. (See 495.304 (c) (1) at 75 FR 44578). Clinic level information is only used when an Individual uses the group patient volume to meet eligibility. This is not based on a group scenario as the two individuals have different patient volumes.

Q: If a Nurse Practitioner (NP) works in a pediatrician's office and the pediatrician only meets the 20% Medicaid patient volume, does the requirement for the NP to meet the 30% patient volume still apply?

A: Yes, the NP must meet the 30% patient volume. Medicaid patient volume required for program eligibility must be consistent with the type of professional applying. In this scenario, the NP needs to have a 30% Medicaid patient volume and the Pediatrician must have a 20% patient volume, even if the professionals are using the group encounter volume to meet program eligibility. The NP qualifies for the full incentive and the Pediatrician qualifies for 2/3 of the incentive. We suggest the EP's explore what their clinic- level would be. If that comes to 30% all EP's in the practice would qualify for the full incentive payment.

Q: Can Medicaid be the secondary insurer when determining total Medicaid patient encounters?

A: When calculating eligible professional or eligible hospital Medicaid patient encounter, Medicaid must pay for all or part of the service or pay for all or part of the individual's premiums and co-payments. If Medicaid pays nothing toward the service then the encounter cannot be counted in the Medicaid numerator.
When calculating eligible professional patient volume at a FQHC/RHC location, Medicaid or Hawk-i must pay for all or part of the service or pay for all or part of the individual's premiums and co-payments, unless the service is offered to an underserved individual at no cost or at a reduced cost.

Q: Can we include out-of-state Medicaid days (and HMO days) in the Medicaid patient threshold eligibility to attain the 10% for Eligible Hospital or 30% for Eligible Professionals? Assume we are NOT selecting different state incentive programs each year.

A: In calculating patient volume, providers can include encounters in which another state's program paid for the encounter. During attestation you will be asked which other state's Medicaid programs (including HMOs) paid for any encounters during the 90-day period.

Q: Does the IDPH have the capacity to accept Immunization records electronically from an EHR?

A: Not at this time.

Q: When will the IDPH be ready to accept Immunization records electronically from an EHR?

A: The IDPH is working with its Health Information Network "HIN" and Immunization System vendors to implement electronic reporting capabilities. We hope to have this functionality available in late 2012.

Q: Does the IDPH have the capacity to accept reportable lab results electronically from an EHR?

A: Not at this time

Q: When will the IDPH be ready to accept reportable lab results electronically from an EHR?

A: The IDPH is working with its Health Information Network "HIN" vendor to implement electronic reporting capabilities. A timeline for implementation has not been solidified.

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